space must be opened as much as possible. This is largely accomplished by flexing the leg on the thigh, and the latter at right angles, which relaxes the anterior capsular wall.

The head of the femur must now be given an approximately frontal direction, thus turning it toward the hiatus of the now relaxed capsular pocket. Although the head is in the proper position to enter the acetabulum, no amount of manual force will drive it in.

The operator, standing on a stool, seizes the thigh, flexed at right angles to the trunk, with one hand, and, with the other grasping the head of the femur, he, by a system of extension combined with rotation and gradually increasing abduction, opens the way into the dormant-lying acetabulum pocket. When the abduction, which must be gradually exerted, has reached a considerable degree, the head of the femur, still manipulated by one hand, is felt to leap over the posterior edge of the acetabulum, and the surgeon feels at once that reposition has taken place. A distinct noise is clearly heard.

The dislocation may recur. To prevent it the angle of abduction must be maintained at not far from 90°. The leg is held in this position by a fixed plaster dressing.

The pain of the operation subsides in a day or two, and the patient is urged to walk. It is advisable to add a few inches to the shoe of the foot of the diseased side and give some support at first, but this walking about constitutes one of the most important parts of the treatment. Growth is reawakened, the parts are reactivated, and a nearthrosis is gradually built up.

OPHTHALMOLOGY.

UNDER THE CHARGE OF

EDWARD JACKSON, A.M., M.D.,

PROFESSOR OF DISEASES OF THE EYE IN THE PHILADELPHIA POLYCLINIC; SURGEON TO WILLS EYE HOSPITAL, ETC.,

AND

T. B. SCHNEIDEMAN, A.M., M.D.,

PROFESSOR OF DISEASES OF THE EYE IN THE PHILADELPHIA POLYCLINIC; ASSISTANT SURGEON TO WILLS EYE HOSPITAL, ETC.

Trophic Keratitis in Caisson Disease.—GEO. C. HARLAN (Philadelphia) reports the case of a man, aged twenty-nine years, who had worked in a caisson under atmospheric pressure increasing from eighteen to thirty pounds in the course of three months. Fellow-workmen had been taken out unconscious, one had died, and one was said to be paralyzed. He had suffered for a month from occasional numbness of the right side, and when obliged to quit work the right eye had commenced to be irritable and painful. Six weeks later it presented a superficial ulcer with infiltration and ill-defined margins. The whole cornea was steamy, but not vascular. Slender posterior synechiæ showed a moderate iritis. There was almost complete anæsthesia of the cornea and conjunctiva and other parts supplied by the first and second branches of the fifth nerve. There was no motor paralysis. The corneal ulcer increased and hypopyon appeared; but perforation of the cornea did not occur, and the eye gradually improved, although still remaining insensitive.

As bearing on the nature of this disease, Harlan points out that the cornea will sometimes slough if exposed, although perfectly sensitive, but it will by no means always do so when insensitive. And he instances a case in which the insensitive cornea remained clear and bright until a progressive lesion produced ptosis, and the cornea was protected from the atmosphere when it rapidly sloughed.—*Trans. Amer. Ophthal. Society*, 1897, p. 103.

Syphilitic Dacryoadenitis.—H. E. JULER (London) says that symmetrical enlargement of the lachrymal glands is, perhaps, one of the rarer affections of the appendages we are liable to meet with, and he has little hesitation in attributing many instances of this condition to syphilis. These tumors start in the upper and outer part of the orbit, first in one, then in the other. Small nodules are felt at first, which multiply until symmetrical lobulated tumors exist, arching inward over the eyeball. Ptosis is the first obvious sign, though puffiness and even slight redness of the eyelids may be noticed. The periosteum may be very extensively involved, so that the nerves and even the muscles at their origin may be interfered with, giving rise to limited movement of the eyeball and anæsthesia of the forehead and scalp. There is no papillitis, the eyeballs do not pulsate, nor are they invaded by the growth. The close of the disease leaves the eyes as perfect as before.

He reports two cases, in one of which the growths continued to increase for six months, and then under increasing doses of potassium iodide and mercury slowly diminished, until a year later the orbits were again normal. In the other case the contents of the orbit were removed for a rapidly growing tumor situated in the region of the lachrymal gland, and supposed, until examined microscopically, to be sarcomatous.—*The Lancet*, December 11, 1897.

Retinal and Optic Nerve Lesions Associated with Gout.—C. S. BULL (New York) finds these to be: Changes in the walls of the bloodvessels of the retina, choroid, and optic nerve, including arteries, capillaries, and veins. Retinitis of a peculiarly localized character, confined to the posterior zone of the fundus, with or without hemorrhages in the retina and vitreous, and characterized by a peculiar yellowish exudation, occurring in clearly defined patches. Optic neuritis, generally with, but sometimes without, an accompanying retinitis. The changes in the fundus are always bilateral, though rarely symmetrical in the two eyes. The lesion may begin simultaneously in the two eyes, but this is by no means always the case. The degenerative changes in the walls of the bloodvessels, both arteries and veins, are at first very minute and often overlooked. They must be carefully searched for, as they begin in the intima.

The general angio-sclerosis and the patchy exudation in the retina cause marked impairment of central vision, but little impairment of the peripheral